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Rural access to healthcare: lessons from down under

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ABSTRACT Access to medical services in rural areas will be an important policy issue for Scotland over the next decade. Lessons can be learned from rural initiatives in other countries; Australia has developed a strategy which takes account of its sparse population, and the many complexities of its health system.

KEYWORDS Access, Australia, rural health, Scotland, specialist services

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The provision of health services to rural communities has involved a great deal of effort and review from health planners, politicians and policy makers over the last two or three decades. It is now recognised internationally that issues such as access to services and equity of provision require special attention in rural communities. Even in the UK, where there is nothing like the remoteness of communities found in countries such as Canada and Australia, it is well recognised that in some rural communities, issues of access and transport are of critical importance. While a community in an outer Hebridean island may not be that far from a major hospital, when one takes into account the vagaries of weather, ferry times, difficulties in landing planes etc the concept of 'remoteness' does become relevant!

In this issue of *The Journal* Pegram *et al,*[1] describe provision of specialist medical services in rural and remote Australia. The Australian healthcare system is, if nothing else, complex. The division of responsibility between state and federal governments, the strong private sector and the general disagregation of service providers mean that national initiatives addressing important health priorities, such as rural and remote health, are necessarily mapped onto a complex web of service providers and funding arrangements. Australia is a vast continent with a small, highly urbanised population, so provision of health services in remote regions is a great challenge.

Historically, it has been difficult to attract GPs, specialists and other service providers to rural areas and this has been addressed by several of the schemes outlined in the Pegram paper. An important step in Australia was the development of an appropriate taxonomy for rurality, which is referred to in the paper. Whilst it may seem on the surface a straightforward process to define different levels of remoteness and rurality, this work on classification has been critical, as without such definitions policies and programmes cannot develop.

An emerging phenomenon in Australia is 'outer metropolitan practice'. Communities on the edge of large sprawling cities suffer many of the same problems of rural and remote communities in terms of access to health services. These are compounded by poor transport, social isolation and problems deriving from socio-economic deprivation.

Whilst problems of healthcare access still exist in Australian rural communities, the various state and national programmes described in the paper have clearly had an impact. Several lessons of international relevance can be drawn from the Australian experience:

1. Complex problems of access in remote communities require novel solutions which take into account local healthcare needs. This applies particularly to the health of indigenous populations; there is a long history in Australia of failed government programmes to address the health of the Aboriginal population which mirrors that of a third world country. Nowadays programmes have a great deal more ownership and direction provided by the indigenous community.

2. Access to services in rural communities cannot develop without appropriate education, training and incentives. There is good evidence that admission procedures to medical schools need to be cognizant of the fact that students drawn from rural areas are more likely to return to those communities. There are parallels with the Scottish Executive's current desire to fill more places in Scottish Medical Schools with Scottish school leavers.

3. Undergraduate medical education needs to provide adequate exposure to rural health. Students need to spend time with good role models and have opportunities to immerse themselves in rural communities. Only in this way can they see the challenges and rewards of a professional life practicing rural medicine.

4. Specialist training programmes need to adapt as they have in Australia to accommodate the specific training needs for rural practice. Whilst in Australia the establishment of a separate college for GPs to 'specialise in rural medicine' has at times been acrimonious, there is no doubt that GPs practicing outside of urban areas require different sets of skills and the provision of this training needs to be formalised and recognised.

5. Finally, there needs to be an adequate system of rewards. In Australia, living in a remote rural community has quite profound implications for the socio-cultural circumstances of doctors and their families. In Britain, rural communities are often quite affluent and the facilities of major cities (such as high quality primary and secondary education) generally remain accessible. A remote community in Australia is, by comparison, isolated. While there are benefits of raising a family in a rural context, it does come at a cost and both GPs and specialists require adequate rewards. In Scotland such a reward system has existed for some time but it is probably not enough to address the growing shortage of doctors in rural communities.

How should these issues progress in Scotland (where there are acute shortages of doctors in rural areas) and the UK? The Review of Basic Medical Education in Scotland[2] recognises the need to train more Scottish doctors and has pointed the way with initiatives such as retaining St Andrews students (these students have until now gone to Manchester after their pre-clinical years). The association between rural background and rural working has been demonstrated in the Scottish rural workforce, and issues of professional isolation and perceived lack of access to amenities are important here, as they are in other countries.[3] Existing medical schools need to do more; Aberdeen has a good track record in placing students in rural communities and this should have positive effects, but other centres are less focused on rural issues. The establishment of new UK medical schools in areas such as Norwich and Exeter must also go some way to promoting the cause of rural health.[4] Britain clearly needs a coordinated workforce strategy to address these issues. Indeed, it is often suggested that the livelihood and social infrastructure of fragile remote communities is dependent upon adequate rural services.[5]

The emergence of Foundation programmes and the wider 'Modernising Medical Careers' initiative[6] are excellent opportunities to ensure Britain takes the best of the rural health models developed in other countries and applies them to its own needs. Indeed, efforts should be made to ensure that rural issues remain at the forefront as these initiatives evolve.

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